

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16172

CERTIFICATE OF DEATH

16170

1. PLACE OF DEATH
a. COUNTY

QUEEN ANNE'S

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

RURAL CENTREVILLE

c. LENGTH OF STAY IN 1b

all his life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

OC

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Sept. 5, 1918

9. AGE (in years
last birthday)

48 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. IS RESIDENCE
ON A FARM?

YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

Farming

13. FATHER'S NAME

Dulin Oliver Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-36-1817

17. INFORMANT

wife

Address

Mrs. Elizabeth D. Clark, Centreville Md.

INTERVAL BETWEEN
ONSET AND DEATH

1 hour

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

Coronary Occlusion

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

Due to

(b)

Due to

(c)

Arteriosclerotic Heart Disease

2 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1960, to Oct. 8, 1966, that (I) (we) last
saw the deceased alive on Oct. 8, 1960, and that death occurred at 10:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

John R. Smith Jr.

M.D. ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)

John R. Smith Jr.

22d. ADDRESS

Centreville, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

Nov. 11, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Chesterfield Cemetery

23d. LOCATION (City, town or county) (State)

Centreville, Maryland 21617

24. FUNERAL DIRECTOR

Jones J. Burton Jr., Burton Bros., Centreville, MD

ADDRESS

2nd flr

25a. READ BY REGISTRAR

NOV 14 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

and ~~now~~ ^{now} ~~now~~
and ~~now~~ ^{now} ~~now~~

July 21. Started ^{at} 6:45 a.m.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16173

CERTIFICATE OF DEATH

16171

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill 3 weeks		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Arms Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eliza (Lida)	First Middle COVERDALE	4. DATE OF DEATH Nov. 5, 1966	Month Day Year 19
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1872
9. AGE (In years last birthday) 94 yrs.	10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Flagtown, New Jersey
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Henry Pratt		
14. MOTHER'S MAIDEN NAME Sallie Reynolds	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. 213 50 5943	17. INFORMANT Helen Hill	Address Washington Ave.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia - Chronic renal insufficiency</i> years 4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>A. S. C. V.D.</i> years (c) <i>Prob. Chronic pyelonephritis</i> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>G.I. hemorrhage due to Uremia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10-7</i> , 19 <i>66</i> , to <i>11-5</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>11-5</i> , 19 <i>66</i> and that death occurred at <i>324 M</i> , from the causes and on the date stated above.	22a. SIGNATURE <i>Harry Paul Ross</i>		
22b. DATE SIGNED <i>11/5/66</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) Harry Paul Ross	22d. ADDRESS Chestertown, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/7/66	23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows Cem.	23d. LOCATION (City, town or county) (State) Smyrna, Delaware
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE NOV 9 1956	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill		c. LENGTH OF STAY IN 1b 1½ years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Colonial Arms Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Nannie	Middle Hadaway	4. DATE OF DEATH 11/21/66
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 75 yrs.
11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Newcomb		14. MOTHER'S MAIDEN NAME Joanna Diehl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Walter Hadaway
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Address Chestertown, Md. RFD Q.A. Co.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Haemoragic Purpura, Arthrosclerotic Disease		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 10 1966, to Nov 21, 1966, that (I) (we) last saw the deceased alive on Nov 21 1966, and that death occurred at 522X, from the causes and on the date stated above.		22b. DATE SIGNED 11/22/66	
22a. SIGNATURE C. Rodney Layton M.D.		22d. ADDRESS Centreville, Md.	
22c. PHYSICIAN'S NAME (Type) C. Rodney Layton		23d. LOCATION (City, town or county) (State) Rock Hall, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR NOV 25 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

McCallister

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16175 16173

1. PLACE OF DEATH a. COUNTY <i>Ocega Anne's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL <i>Centreville</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4 Knoll Ridge Court</i>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Romilly</i>	First <i>Francis</i>	Middle <i>Humphries</i>	Last <i>III</i>
4. DATE OF DEATH <i>November 11 1966</i>	Month <i>November</i>	Day <i>11</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1931</i>
9. AGE (in years last birthday) <i>35</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>35</i>	11. IF UNDER 24 HRS <input type="checkbox"/> Days <i>0</i>	12. IF UNDER 24 HRS <input type="checkbox"/> Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Romilly Francis Humphries Jr.</i>		
14. MOTHER'S MAIDEN NAME <i>Jean B. Cotton</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <i>Yes</i> 16. SOCIAL SECURITY NO. <i>218-28-5320</i> 17. INFORMANT SISTER <i>Mrs. Frederica Jay Chalfant</i> Address <i>3925 Clarendon Rd., Baltimore, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>976X</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Shot in head with 9mm Auto-matic</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>Nov 11 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rest near 204</i>
20f. (City or town) <i>Centreville</i> (County) <i>Md</i> (State) <i>—</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>C. P. Layton</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>C. P. Layton</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-14-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Johns</i>
23d. LOCATION (City, town or county) <i>Baltimore Co., Md.</i>		22. DATE SIGNED <i>11-11-66</i>	
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home, Inc.</i>		25a. ADDRESS <i>6500 York Rd., Baltimore, Md. 21212</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
25a. REC'D BY REGISTRAR <i>NOV 15 1956</i>		25b. DATE <i>NOV 15 1956</i>	

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16176

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16174

1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE		c. LENGTH OF STAY IN 1b 60 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 00		d. STREET ADDRESS GRASONVILLE 171		
3. NAME OF DECEASED (Type or print) BARBARA		First JEWELL	Last Month Day Year NOVEMBER 12, 1966	
5. SEX FEMALE		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH DEC. 28, 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home		
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK Sliuka		14. MOTHER'S MAIDEN NAME Antonia ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-1808-0		
17. INFORMANT Mrs. Marie A. Capel, Grasonville, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH		
1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO				
(c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PNEUMONIA				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-12 , 19 66 , to 11-12 , 19 66 , that (I) saw last saw the deceased alive on 11-11 , 19 66 , and that death occurred at 7:24 AM , from the causes and on the date stated above.		22b. DATE SIGNED 11-13-66		
22a. SIGNATURE Ralph E. Libby		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Ralph E. Libby, M.D.		22d. ADDRESS Grasonville, Maryland 21638		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery	23d. LOCATION (City, town or county) (State) Centreville, Maryland 21617
24. FUNERAL DIRECTOR Donald H. Bunting, Jr., Bunting Bros., Centreville, Md. 21617		ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
			DATE NOV 15 1956	

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